

# R I DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

=60-030406

DEED

SEP 12 1960 149 Registration District No. Primary Registration District No. 1002 Registrar's No. 4359

STATE FILE NUMBER

1. PLACE OF DEATH a. COUNTY <b>Jackson</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Missouri</b> b. COUNTY <b>Jackson</b>			
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>Kansas City</b>		Length of stay in 1b <b>15 yrs.</b>		c. CITY OR TOWN <b>Raytown</b>		Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>Research Hospital</b>		Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>		d. STREET ADDRESS (If outside, give location) <b>9309 E. 64th.</b>		Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>Clifford</b> Middle <b>Allison</b> Last <b>Allison</b>				4. DATE OF DEATH Month <b>August</b> Day <b>24</b> Year <b>1960</b>			
5. SEX <b>male</b>	6. COLOR OR RACE <b>white</b>	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <b>3-27-1905</b>	9. AGE (last birthday) <b>55</b>	IF UNDER 1 YEAR Months <b>55</b> Days <b>55</b>		IF UNDER 24 HR Hours <b>55</b> Min. <b>55</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>truck driver Transport</b>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (City and state or country) <b>Brookfield, Mo.</b>		12. CITIZEN OF WHAT COUNTRY <b>U. S. A.</b>	
13a. FATHER'S NAME <b>Salathiel Allison</b>		13b. MOTHER'S MAIDEN NAME <b>Gertrude F. Griffith</b>		14. NAME OF HUSBAND OR WIFE <b>Anna Allison</b>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>no</b>		16. SOCIAL SECURITY NO. <b>unknown</b>		17. INFORMANT <b>Anna Allison Raytown, Mo.</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>recurrent carcinoma of stomach</b>						INTERVAL BETWEEN ONSET AND DEATH <b>6 yrs.</b>	
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) _____ DUE TO (c) _____							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)						PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)					
20c. TIME OF INJURY Hour <b>a.m.</b> Month, Day, Year							
20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	20f. CITY, TOWN, OR LOCATION		COUNTY		STATE	
21. I attended the deceased from <b>Oct. 1954</b> to <b>8-24-60</b> and last saw her/him alive on <b>8-24-60</b> . Death occurred at <b>6:15 P.</b> on the date stated above, and to the best of my knowledge, from the causes stated.							
22a. SIGNATURE  (Degree or title) <b>M.D.</b>		22b. ADDRESS <b>701 E. 63rd.</b>		22c. DATE SIGNED <b>8-25-60</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>removal</b>	23b. DATE <b>8-25-60</b>	23c. NAME OF CEMETERY OR CREMATORY <b>-</b>		23d. LOCATION (City, town, or county) <b>Brookfield, Mo.</b>		(State)	
24. FUNERAL DIRECTOR <b>Hill Mortuary</b>		ADDRESS <b>Brookfield, Mo.</b>		25. DATE RECD. BY LOCAL REG. <b>8-25-60</b>		26. REGISTRAR'S SIGNATURE <b>H. L. Dwyer</b>	

(Licensed Embalmer's Statement on Reverse Side)

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

E. A. Quer

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was  
by me, or by ..... , Student Embalmer No. ....  
working under my personal supervision.

Student .....  
Signature of Student Embalmer

Signed  .....

Licensed Embalmer No. ....

P. O. Address .....

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING  
to comply with the above constitutes grounds for revocation of license).

If embalmed by a STUDENT, he also shall sign in his OWN handwriting.

If this body is not embalmed, fact should be so stated above.